dhec
SC Department of Health and Environmental Control

INSPECTION RESULTS

Facility Information		Audit Information	
Permit Number:	RTF-0014	**Audit Name:**	RTF ROV 20161020
Facility Name:	PALMETTO PEE DEE RESIDENTIAL TREATMENT CENTER	**Type:**	L07 Investigation
		Start Date:	13 Dec 2016 08:30 AM
Address:	601 GREGG AVE STE B	**End Date:**	13 Dec 2016 02:30 PM
City/State/Zip:	FLORENCE, SC 29501-4316 Florence	**Inspector:**	Erika Edwards
Phone 1:	843-667-0644	**Score:**	0.0%
Email:	GREGORY.JOHNSON@UHSINC.COM		
Contact Name:	LAKESHIA COAKLEY		
Contact Email:	null		
Contact Phone:	803-348-2183		

Overall Score
0.0%

Report Notice

Question	Answer	Percent
Bureau of Health Facilities Licensing 2600 Bull St Columbia SC 29201-1708 REPORT NOTICE: If applicable, this Report of Visit includes a detailed description of the conditions, conduct or practices that were found to be in violation of requirements. This inspection or investigation is not to be construed as a check of every condition that may exist, nor does it relieve the licensee (owner) from the need to meet all applicable standards, regulations and laws. The South Carolina Code of Laws requires this Department to establish and enforce basic standards for the licensure (permitting), maintenance, and operation of health facilities and services to ensure the safe and adequate treatment of persons served in this State. It also empowers the Department to require reports and make inspections and investigations as considered necessary. Furthermore, the Code authorizes the Department to deny, suspend, or revoke licenses (permits) or to assess a monetary penalty against a person or facility for (among other reasons), violating a provision of law or departmental regulations or conduct or practices detrimental to the health or safety of patients, residents, clients, or employees of a facility or service. If applicable to the type of report being made, the signature of the activity representative indicates that all of the items cited were reviewed during the exit discussion. If this Report of Visit is required by regulation to be made available in a conspicuous place in a public area within the facility, redaction of the names of those individuals in the report is required as provided by Sections 44-7-310 and 44-7-315 of the S.C. Code of Laws, 1976, as amended.	Report Notice	
Totals		

Administrator's Signature - Plan of Correction

Question	Answer	Percent
PLAN OF CORRECTION - Administrators Certification: I certify that the attached plan of correction describes: (1) the actions taken to correct each cited deficiency, (2) the actions taken to prevent similar recurrences, and (3) the actual or expected completion dates of those actions.	POC REQUIRED	

PRINT NAME: Lakeshia COAKLEY

TITLE: Executive Director

SIGNATURE: Lakeshia Coakley

DATE: 1/4/17

Any violations cited in this report of visit were observed at the time of the inspection.

The Administrator submits an electronic plan of correction by visiting the website http://www.scdhec.gov/Health/FHPF/HealthFacilityRegulationsLicensing/HealthcareFacilityLicensing/CorrectionPlan/ and following the instructions online.

Or the Administrator returns a copy of this report (original signature required) with description of corrective actions to:

SCDHEC, Bureau of Health Facilities Licensing, 2600 Bull St, Columbia, SC, 29201

Your response to this report must be received in our office by close of business (5:00 p.m.) no later than the date listed below:

Comments

- *The Plan of Correction (POC) is due 15 days from receipt of this Report of Visit (ROV).*

Totals		

Inspection Information

Question	Answer	Percent
Inspection Includes Licensing:	YES	
Inspection Includes Food/Sanitation:	NO	
Inspection Includes Fire & Life Safety:	NO	
Is this an On-Site Visit?	YES	
Select the Type of Inspection to be Performed:	RTF Complaint Investigation	
Section Team Log Number: **Comments** • *M12017-16*	Section Team Log Number	
Reason for Investigation: **Comments** • ***A complaint received by the Bureau of Health Facilities Licensing was investigated. The complaint alleged the following:*** *A client/resident was admitted to the facility on [redacted] weighing 132lbs. S/he now weighs 96.6lbs. The client has been bitten 4-5 times by other clients at the facility within the last 4 months. S/he is always visibly dirty and filthy .*	Reason for the Investigation.	
What is the Source:	Consumer Complaint	
Date Agency (DHEC) Notified: **Comments** • *12/7/16*	Date Agency (DHEC) Notified:	
Detailed Results of this Investigation: **Comments** • ***To investigate this complaint, an unannounced on-site visit was made to the facility by (2) representatives of the Department. The investigation consisted of the following:*** *Individual treatment plans (ITP), weekly nursing summaries, 15-minute observations, medication administration records, clinical assessments, dietary assessments, staff assignment sheets, unit census including resident diagnosis, incident/accident logs and reports, policies and procedures, body audit reports, activities of daily living logs, and interviews with the staff and Resident A.* *As a result of this investigation, the following violations of Regulation 61-103, Residential Treatment Facilities for Children and Adolescents, were cited.*	Detailed Results	
Is this an Unlicensed Facility/Activity Complaint?	NO	

PLAN OF CORRECTION REPORTING FORM
BUREAU OF HEALTH FACILITIES LICENSING

1/11/2017 Did Not accept LS

INSPECTION INFORMATION

License Number:

RTF-0014

Facility Type:

HL- Residential Treatment for Children & Adolescents

Facility Name:

PALMETTO PEE DEE RESIDENTIAL TREATMENT CENTER

Inspection Date:

12/13/2016

Submission Date:

01/04/2017

Type of Inspection:

Investigation

ADMINISTRATOR'S CERTIFICATION

By checking this box, I attest that I am the administrator of the facility/activity and that this plan of correction is accurate. Additionally, I certify that the plan of correction describes the actions taken to correct each cited deficiency, the actions taken to prevent similar recurrences and the actual or expected completion date.

Checked

Administrator Name:

Lakeshia Coakley

E-mail:

lakeshia.coakley@uhsinc.com

Phone:

(843) 667-0644

RESPONSE TO CITATIONS

Section:	Was Completion Date Provided?	Completion Date (Actual or Expected):
400.A	Yes	01/18/2017

Corrective Action:

By submitting this Plan of Correction, Palmetto Pee Dee does not agree that the facts alleged are true or admit it violated the rules. Policy #NSG 27 has been revised and staff re-trained. After an initial screening by the nurse, new residents receive a nutritional consult within 2 weeks from the date of admission. Special diets will be ordered by the physician. It is the responsibility of the Director of Nursing (DON) to ensure communication to and implementation by the dietary staff.

Preventive Action:

The DON will review Dietary Communication forms on a monthly basis and make any necessary corrections and/or provide staff training, as needed.

Optional Comments:

I sent by email to the facility stating we do not support the disclaimer at the top. This attached to the Steton packet. L. Sanders, LPN

Response Approved:

Yes

Section:	Was Completion Date Provided?	Completion Date (Actual or Expected):
504.B	Yes	12/30/2016

Corrective Action:

The program will continue to meet Medicaid and DHEC standards by providing sufficient supervision and staffing at all times. Residents are not maintained in one place throughout the day. Residents attend class, participate in recreational activities directed by the Rec Therapist, and transition to/from other portions of the program (i.e individual and group therapy, consults, etc.). Additional activities have also been implemented to ensure therapeutic engagement.

Preventive Action:

Incidents are tracked and monitored. Team Leads, the Milieu Manager and Nursing are available for staffing assistance. If incidents are not decreased, Risk Management and Leadership will increase unit activities and revisit daily schedules.

Optional Comments:

Response Approved:

No

Section:	Was Completion Date Provided?	Completion Date (Actual or Expected):
504.C	Yes	12/30/2016

Corrective Action:

Documentation for the date in question (10/8/16) was provided, however the shift was not circled. The Milieu Manager will provide documentation training to the Team Leads, and review for compliance weekly.

Preventive Action:

The Milieu Manager will ensure Shift Report documentation compliance by routine auditing and provide staff re-training as necessary. Shift reports will be maintained on site for a period of no less than 2 years with overflow stored/managed by off site storage company. Any off site records can be retrieved within 24 hours.

Optional Comments:

Response Approved:

No

Section:	Was Completion Date Provided?	Completion Date (Actual or Expected):
704.A	Yes	01/18/2017

Corrective Action:

A new treatment plan format will be implemented mid-January, which will prompt review of nutritional needs. Clinical therapist will be trained on the new format. The program will ensure regular BMI documentation for all residents. The DON, or designee, will address weight gains/loss during each treatment team.

Preventive Action:

Clinical and nursing audits will be conducted on a routine basis by the Clinical Director and the DON, or their respective designee(s). The DON or designee, will review residents BMI's and ensure that findings are addressed in treatment team.

Optional Comments:

Response Approved:

Yes

Section:	Was Completion Date Provided?	Completion Date (Actual or Expected):
704.C.1	Yes	01/18/2017

Corrective Action:

The written policy and procedure #CS045 has been revised to address requirements and arrangements for visits by or to physicians or other authorized healthcare providers on the treatment plan. Clinical therapist will be trained on this treatment plan revision by 1/18/2017.

Preventive Action:

Clinical audits will be conducted by the Clinical Director to ensure implementation.

Optional Comments:

Response Approved:

Yes

Section:	Was Completion Date Provided?	Completion Date (Actual or Expected):
704.C.2	Yes	01/18/2017

Corrective Action:

The written policy and procedure #CS045 has been revised to better address recreational and social activities which are suitable, desirable, and important to the well-being of the resident. Clinical therapist will be trained on this treatment plan revision by 1/18/2017.

Preventive Action:

Clinical audits will be conducted by the Clinical Director to ensure implementation.

Optional Comments:

Response Approved:

Yes

Section:	Was Completion Date Provided?	Completion Date (Actual or Expected):
704.C.3	Yes	01/18/2017

Corrective Action:

The written policy and procedure #CS045 has been revised to better address nutritional needs of the resident. Clinical therapist will be trained on this treatment plan revision by 1/18/2017.

Preventive Action:

Clinical audits will be conducted by the Clinical Director to ensure implementation.

Optional Comments:

Response Approved:

Yes

Section:	Was Completion Date Provided?	Completion Date (Actual or Expected):
704.D	Yes	12/22/2016

Corrective Action:

Both existing treatment plans and the newly revised plan(s) delineate staff responsibilities for each intervention by position (i.e. clinical therapist, mental health tech, nurse, etc.).

Preventive Action:

Clinical audits will be conducted by the Clinical Director to ensure that correct staff position meets the intervention. (i.e. toileting=MHT with nursing oversight).

Optional Comments:

Response Approved:

Yes

Section:	Was Completion Date Provided?	Completion Date (Actual or Expected):
902.F.1	Yes	01/18/2017

Corrective Action:

The program's 2016 written Plan of Care in the Clinical Manual documents the service array and clinical components of the resident's stay in treatment. This has been revised for 2017 to better address the facility's philosophy with regards to group size, composition and supervision.

Preventive Action:

The program will continue to monitor incidents to ensure adequate staffing for various groups and activities. Staff training is on-going. If incidents are not reduced, scheduling will be revisited. Team Leads and Milieu Manager are always available for assistance.

Optional Comments:

Response Approved:

No

Section:	Was Completion Date Provided?	Completion Date (Actual or Expected):
1002.A.6	Yes	12/30/2016

Corrective Action:

The program continues to ensure that each resident be afforded the right to be free from harm, including isolation, excessive medication if applicable, abuse or neglect. Staffing meets all Medicaid and DHEC standards and additional staff (i.e. Team Leads, Milieu Manager, Leadership) are available as needed. The program will continue to monitor incidents and provide support to staff as necessary.

Preventive Action:

Incidents are tracked monthly and addressed in Performance Improvement and Leadership. Risk Management continue to provide oversight and guidance with respect to scheduling, daily activities and incident reduction. Staff training is on-going and camera's reviewed for training purposes and to ensure complaince to standards.

Optional Comments:

Response Approved:

No

LOG INFORMATION SECTION

Report of Visit Delivery Date:

12/21/2016

Plan of Correction Due Date:

1/5/2017

Date Plan of Correction was Reviewed:

01/10/2017

Reviewed by:

L. Sanders, LPN

Comments:

Plan of Correction Approved:

No

Decision By:

L. Sanders, LPN

Decision Date:

01/11/2017

Remove POC:

UPLOAD DOCUMENTS

File Upload

Plan of Correction Log Number:

MPC01014-17

MDC01014-17 LS

PLAN OF CORRECTION

BUREAU OF HEALTH FACILITIES LICENSING

2600 BULL STREET, COLUMBIA, SC, 29201

OFFICE (803) 545-4370 FAX (803) 545-4212 E-MAIL BHFL@dhec.sc.gov

NOTICE: Information on the audit inspection form will be needed to assist you in completing this form.

Inspection Date: 12/13/2016	Today's Date: 12/27/2016	License Prefix: *RTF* Suffix #: 14

Type of Inspection: *L07 INVESTIGATION*

Name of Facility/Activity: Palmetto Pee Dee Behavioral Health

Administrators Certification: ☒ By checking this box, I attest that I am the administrator of the facility/activity and that this plan of correction is accurate. Additionally, I certify that the plan of correction describes the actions taken to correct each cited deficiency, the actions taken to prevent similar recurrences and the actual or expected completion date.

Administrator Name: Lakeshia Coakley E-mail: lakeshia.coakley@uhsinc.com Phone: 8436670644

RESPONSE TO CITATIONS

LS

1/18/2017 Completion Date (Actual or Expected)

Section: 400.A. NA Disclaimer

Corrective Action: "By submitting this Plan of Correction, Palmetto Pee Dee does not agree that the facts alleged are true or admit it violated the rules." Policy #NSG 27 has been revised and staff re-trained. After an initial screening by the nurse, new residents receive a nutritional consult within 2 weeks from the date of admission. Special diets will be ordered by the physician. It is the responsibility of the Director of Nursing (DON) to ensure communication to and implementation by the dietary staff.

Preventive Action: The DON will review Dietary Communication forms on a monthly basis and make any necessary corrections and/or provide staff training, as needed.

NA

12/30/2016 Completion Date (Actual or Expected)

Section: 504.B.

Corrective Action: The program will continue to meet Medicaid and DHEC standards by providing sufficient supervision and staffing at all times. Residents are not maintained in one place throughout the day. Residents attend class, participate in recreational activities directed by the Rec Therapist, & transition to/from other portions of the program (i.e. individual & group therapy, consults,etc). Additional activities have also been implemented to ensure therapeutic engagement.

Preventive Action: Incidents are tracked and monitored. Team Leads,the Milieu Manager & Nursing are available for staffing assistance. If incidents are not decreased, Risk Management and Leadership will increase unit activities & revisit daily schedules.

LS

12/30/2016 Completion Date (Actual or Expected)

Section: 504.C.

Corrective Action: Documentation for the date in question (10/8/16) was provided, however the shift was not circled. The Milieu Manager will provide documentation training to the Team Leads, and review for compliance weekly.

NA

Preventive Action: The Milieu Manager will ensure Shift Report documentation compliance by routine auditing and provide staff re-training as necessary. Shift reports will be maintained on site for a period of no less than 2 years with overflow stored/managed by off site storage company. Any off site records can be retrived within 24 hours.

LS

1/18/2017 Completion Date (Actual or Expected)

Section: 704.A.

Corrective Action: A new treatment plan format will be implented mid-January, which will prompt review of nutritional needs. Clinical therapists will be trained on the new format. The program will ensure regular BMI documentation for all residents. The DON, or desginee, will address weight gains/loss during each treatment team.

Preventive Action: Clinical and nursing audits will be conducted on a routine basis by the Clinical Director and the DON, or their respective desginee(s). The DON or designee, will review residents BMI's and ensure that findings are addressed in treatment team.

1/18/2017 Completion Date (Actual or Expected)

Section: 704.C.1

Corrective Action: The written policy and procedure #CS045 has been revised to address requirements and arrangements for visits by or to physicians or other authorized healthcare providers on the treatment plan. Clinical therapists will be trained on this treatment plan revision by 01/18/2017.

Preventive Action: Clinical audits will be conducted by the Clinical Director to ensure implementation.

1/18/2017 Completion Date (Actual or Expected)

Section: 704.C.2

Corrective Action: The written policy and procedure #CS045 has been revised to better address recreational and social activities which are suitable, desireable, and important to the well-being of the resident. Clinical therapists will be trained on this treatment plan revision by 01/18/2017.

Preventive Action: Clinical audits will be conducted by the Clinical Director to ensure implementation.

1/18/2017 Completion Date (Actual or Expected)

Section: 704.C.3

Corrective Action: The written policy and procedure #CS045 has been revised to better address nutritional needs of the resident. Clinical therapists will be trained on this treatment plan revision by 01/18/2017.

Preventive Action: Clinical audits will be conducted by the Clinical Director to ensure implementation.

12/22/2016 Completion Date (Actual or Expected)

Section: 704.D.

Corrective Action: Both existing treatment plans and the newly revised plan(s) delineate staff responsibilites for each intervention by position (i.e. clinical therapist, mental health tech, nurse, etc.).

Preventive Action: Clinical audits will be conducted by the Clinical Director to ensure that correct staff position meets the intervention (i.e. toileting = MHT with nursing oversight).

You can download this form as many times as needed in order to answer all citations. Is this a continuation page? Yes ☒ No ☐

2 Page Number (if you answered Yes to the question above)

Send completed form by e-mail at BHFL@dhec.sc.gov or by mail to SCDHEC, BHFL, 2600 Bull St, Columbia, SC, 29201

INSTRUCTIONS: DHEC FORM 0275
PLAN OF CORRECTION
BUREAU OF HEALTH FACILITIES LICENSING (BHFL)

PURPOSE: Provide facilities or services with a form to respond to citations after an inspection was conducted by the Department.

EXPLANATION: This form is used by facilities or activities, licensed by the Department through the Bureau of Health Facilities Licensing, to respond to citations made from an inspection.

Item by Item Instructions:

1. Inspection Date: From information on the inspection audit, enter the date the inspection was conducted at the facility.

2. Today's Date: Enter the date you are completing this form.

3. License Prefix & Suffix: From information on the inspection audit, choose the license prefix and then enter the suffix number (this is the license number that appears on your license).

D H E C
PROMOTE PROTECT PROSPER
South Carolina Department of Health and Environmental Control

PLAN OF CORRECTION

BUREAU OF HEALTH FACILITIES LICENSING

2600 BULL STREET, COLUMBIA, SC, 29201

OFFICE (803) 545-4370 FAX (803) 545-4212 E-MAIL BHFL@dhec.sc.gov

NOTICE: Information on the audit inspection form will be needed to assist you in completing this form.

Inspection Date: 12/13/2016	Today's Date: 12/27/2016	License Prefix: *RTF* Suffix #: 14

Type of Inspection: *L07 INVESTIGATION*

Name of Facility/Activity: Palmetto Pee Dee Behavioral Health

Administrators Certification: ☒ By checking this box, I attest that I am the administrator of the facility/activity and that this plan of correction is accurate. Additionally, I certify that the plan of correction describes the actions taken to correct each cited deficiency, the actions taken to prevent similar recurrences and the actual or expected completion date.

Administrator Name: Lakeshia Coakley E-mail: lakeshia.coakley@uhsinc.com Phone: 8436670644

RESPONSE TO CITATIONS

1/18/2017 Completion Date (Actual or Expected)

Section: 902.F.1

Corrective Action: The program's 2016 written Plan of Care in the Clinical Manual documents the service array and clinical components of the resident's stay in treatment. This has been revised for 2017 to better address the facility's philosophy with regard to group size, composition and supervision.

Preventive Action: The program will continue to monitor incidents to ensure adequate staffing for various groups and activities. Staff training is on-going. If incidents are not reduced, scheduling will be revisited. Team Leads and Milieu Manager are always available for assistance.

12/30/2016 Completion Date (Actual or Expected)

Section: 1002.A.6

Corrective Action: The program continues to ensure that each resident be afforded the right to be free from harm, including isolation, excessive medication if applicable, abuse or neglect. Staffing meets all Medicaid and DHEC standards and additonal staff (i.e. Team Leads, Nurse, Milieu Manager, Leadership) are available as needed. The program will continue to monitor incidents and provide support to staff as necessary.

Preventive Action: Incidents are tracked monthly and addressed in Performance Improvement and Leadership. Risk Management continues to provide oversight and guidance with respect to scheduling, daily activities and incident reduction. Staff training is ongoing and camera's reviewed for training purposes & to ensure compliance to standards.

Completion Date (Actual or Expected)

Section:

Corrective Action:

Preventive Action:

Completion Date (Actual or Expected)

Section:

Corrective Action:

Preventive Action:

Completion Date (Actual or Expected)

Section:

Corrective Action:

Preventive Action:

Completion Date (Actual or Expected)

Section:

Corrective Action:

Unacceptable POC

Sanders, Lorie D.

Wed 1/11/2017 1:18 PM

To: lakeshia.coakley@uhsinc.com <lakeshia.coakley@uhsinc.com>;

Bcc: Smith, Angie <smithag@dhec.sc.gov>; Kelly, Shelly B. <KELLYSB@dhec.sc.gov>; Thompson, Gwendolyn <thompsgw@dhec.sc.gov>; English, Terry <englistl@dhec.sc.gov>;

Importance: High

1 attachments (164 KB)

Investigation Palmetto Pee Dee.pdf;

Ms. Coakley,

Thank you for sending in your Plan of Correction for Palmetto Pee Dee Residential Treatment Center. This was an investigation M12017-16 report of visit dated December 13, 2016 .As a result of our review, the Department has determined that the Facility's Plan of Correction does not adequately address a corrective and/or preventive action for the cited violations stated below. Therefore, the Plan of Correction **is not acceptable due to the following reasons:**

400.A : The Department does not accept the disclaimer "By submitting this Plan of Correction, Palmetto Pee Dee does not agree that the facts alleged are true or admit it violated the rules." We did accept the corrective action and the preventive action that you had listed nothing else needs to be addressed with this violation.

504.B: Your response to the correction action is not accepted, and your preventative action does not state how this violation will be preventive in the future.

504.B: The response to the corrective action is accepted, however your response to the preventative action is not accepted.

902.F.1: The response to the corrective action is accepted, however your response to the preventative action is not accepted.

1002.A.6: Your response to the correction action is not accepted, and your preventative action does not state how this violation will be preventive in the future.

Palmetto Pee Dee Residential Treatment Facility must complete an amended Plan of Correction addressing the above deficiencies. **The amended Plan of Correction must be received by the Department on or before Monday January 16, 2016 or a citation by mail will be sent.**

Please submit this Plan of Correction or our website using the below link

http://www.scdhec.gov/Health/FHPF/HealthFacilityRegulationsLicensing/HealthcareFacilityLicensing/CorrectionPlan

Re: unacceptable POC

Sanders, Lorie D.

Wed 1/11/2017 3:41 PM

To:Buhl, Linda <Linda.Buhl@uhsinc.com>;

I apologize for the error.

It should be 504.B The correction action was not accepted, and the preventive action does not state how this violation will be preventive in the future.

504.C The preventive action is not accepted.

Thanks for bring this to my attention.

Lorie D.Sanders, LPN
Complaint Department
South Carolina Department of Health and Environmental Control
Bureau of Health Facilities Licensing
Columbia Mills
Office: 803-545-4240
Fax: 803-545-4212

"This email is intended only for the use of the individual or entity to which it is addressed and may contain information which is privileged and confidential. If the reader of this email is not the intended recipient, you are hereby notified that any disclosure, distribution, or copying of this information is strictly prohibited. If you received this email in error, please notify the sender immediately by reply."

From: Buhl, Linda <Linda.Buhl@uhsinc.com>
Sent: Wednesday, January 11, 2017 2:55:39 PM
To: Sanders, Lorie D.
Cc: Coakley, Lakeshia
Subject: unacceptable POC

Ms. Sanders – in reading your email regarding our POC, it references "504.A" It goes on to say the response is not accepted and on the next line it states it is accepted, but the preventative action is not.

I don't see a 504 A on the report. Please clarify as this applies to two separate and distinct citations.
(I also left a message on your telephone). Thanking you in advance,

Linda Buhl
Director of Health Information Services
Palmetto Pee Dee Behavioral Health
601B Gregg Avenue
Florence, SC 29501
(843) 667-0644

UHS of Delaware, Inc. Confidentiality Notice: This e-mail message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution of this information is prohibited, and may be punishable by law. If this was sent to you in error, please notify the sender by reply e-mail and destroy all copies of the original message.

Any questions or concerns please let us know.

Lorie D.Sanders, LPN
Complaint Department
South Carolina Department of Health and Environmental Control
Bureau of Health Facilities Licensing
Columbia Mills
Office: 803-545-4240
Fax: 803-545-4212

"This email is intended only for the use of the individual or entity to which it is addressed and may contain information which is privileged and confidential. If the reader of this email is not the intended recipient, you are hereby notified that any disclosure, distribution, or copying of this information is strictly prohibited. If you received this email in error, please notify the sender immediately by reply."

Read: [External]Unacceptable POC

Coakley, Lakeshia <Lakeshia.Coakley@uhsinc.com>

Wed 1/11/2017 1:49 PM

Inbox

To: Sanders, Lorie D. <SANDERLD@dhec.sc.gov>;

Importance: High

Your message

To:
Subject: [External]Unacceptable POC
Sent: Wednesday, January 11, 2017 6:49:02 PM (UTC+00:00) Monrovia, Reykjavik

was read on Wednesday, January 11, 2017 6:48:58 PM (UTC+00:00) Monrovia, Reykjavik.

Relayed: Unacceptable POC

Microsoft Outlook

Wed 1/11/2017 1:18 PM

To:lakeshia.coakley@uhsinc.com <lakeshia.coakley@uhsinc.com>;

Delivery to these recipients or groups is complete, but no delivery notification was sent by the destination server:

lakeshia.coakley@uhsinc.com (lakeshia.coakley@uhsinc.com)

Subject: Unacceptable POC

1/23/2017
LS

PLAN OF CORRECTION REPORTING FORM
BUREAU OF HEALTH FACILITIES LICENSING

INSPECTION INFORMATION

License Number:

RTF-0014

Facility Type:

HL- Residential Treatment for Children & Adolescents

Facility Name:

PALMETTO PEE DEE RESIDENTIAL TREATMENT CENTER

Inspection Date:

12/13/2016

Submission Date:

01/16/2017

Type of Inspection:

Investigation

ADMINISTRATOR'S CERTIFICATION

By checking this box, I attest that I am the administrator of the facility/activity and that this plan of correction is accurate. Additionally, I certify that the plan of correction describes the actions taken to correct each cited deficiency, the actions taken to prevent similar recurrences and the actual or expected completion date.

Checked

Administrator Name:

Lakeshia Coakley

E-mail:

lakeshia.coakley@uhsinc.com

Phone:

(803) 348-2183

RESPONSE TO CITATIONS

Section:	Was Completion Date Provided?	Completion Date (Actual or Expected):
504.B		01/31/2017

Corrective Action:

The facilities policies have been reviewed and found to be compliant with staffing ratio standards. New procedures are in place to ensure that the staffing documentation logs clearly document a minimum of 1 staff to 5 residents during waking/program hours. During sleeping hours, the staffing documentation logs will clearly document a minimum of 1 staff to 7 residents. The logs will provide evidence that a minimum of 2 staff shall be on each unit. At least one male and one female direct care staff shall be present, awake and available. Staff will initial their names on the appropriate shift log. Staffing log documentation re-training was provided by the Milieu Manager to the Team Leads on 01/13/17. In addition, the lower functioning unit has been divided into those who are more aggressive and those who are less aggressive. Additional unit activities have also been implemented. A new reward system has been introduced as an incentive for good behavior. Incidents are staffed daily during the morning rounds and during daily staff shift briefing(s). Additional staff will be made available to assist as necessary.

Preventive Action:

The Milieu Manager will review staffing logs daily to ensure staff to client ratios are observed and so documented. The Executive Director will provide oversight. Any errors found will be shared with Leadership Team and corrected. Staff documentation re-training will be conducted as necessary. Incident reduction will be discussed and addressed each week in Leadership Team. Incidents are also tracked and reported

monthly for performance improvement. Program leadership will monitor incidents during daily leadership meetings and develop specific plans to address any identified trend with either one individual youth or a collective unit. Staff ratios will be altered by leadership to respond to the needs of the youth to ensure optimum treatment opportunities.

Optional Comments:

Response Approved:

Yes

Section:	Was Completion Date Provided?	Completion Date (Actual or Expected):
504.C		01/31/2017

Corrective Action:

N/A - accepted in previous plan of correction

Preventive Action:

Staffing log documentation re-training was provided by the Milieu Manager to the Team Leads on 01/13/17. The Milieu Manager will review staffing logs daily to ensure staff to client ratios are observed and so documented. The Executive Director will provide oversight. Any errors found will be shared with Leadership Team and corrected. Staff documentation re-training will be conducted as necessary.

Optional Comments:

Response Approved:

Yes

Section:	Was Completion Date Provided?	Completion Date (Actual or Expected):
902.F.1		01/31/2017

Corrective Action:

N/A - accepted in previous plan of correction

Preventive Action:

The program will ensure compliance with staff to client ratios and during all therapeutic programming, and ongoing compliance through documentation review and Leadership Rounds camera review. Any errors found will be shared in weekly Leadership meetings and documentation corrected. The Executive Director will provide oversight. Staff re-training will be provided as necessary. Incident reduction will be a method by which staff involvement and group size will be reviewed and monitored. The program will also provide additional staff training during monthly All Staff trainings, Dine and Development trainings and as needed to further the therapeutic environment beginning 01/31/17. Program leadership will monitor incidents during daily leadership meetings and develop specific plans to address any identified trend with either one individual youth or a collective unit. Staff ratios will be altered by leadership to respond to the needs of the youth to ensure optimum treatment opportunities. Leadership also will also provide daily on-sight review through direct observation.

Optional Comments:

Response Approved:

Yes

Section:	Was Completion Date Provided?	Completion Date (Actual or Expected):
1002.A.6		01/31/2017

Corrective Action:

Palmetto Pee Dee will ensure that each resident will be afforded the following rights: 6.The right to be free from harm, including isolation, excessive medication, if applicable, abuse or neglect. Resident A had bite marks on more than one occasion and was bitten by another peer in more than one setting (i.e. group, class). The program has divided the lower functioning unit into those who are more aggressive and those who are less aggressive. A "Special Incident Review" meeting has been developed to address high risk behaviors and incidents. The DON, Director of Risk Management, ED, Director of Clinical Services, the Patient Advocate and Director of Medical Records will provide input. The meeting will be held weekly and/or as needed, to better identify and address high risk behaviors/residents. Team Leads will also prompt staff during daily shift briefings to report any high risk behaviors and/or potential residential conflict observed.

Preventive Action:

The program will continue to ensure resident's rights in the following ways: discussion/alerts by staff of resident behaviors during daily shift briefings (led by the Team Leads), discussions/alerts of high risk behaviors during daily Rounds meetings (if roommate changes are necessary, they will be made under the direction of the Clinical Director and Milieu Manager), Special Incident Review meetings held weekly or more frequently as needed, to address high risk behaviors/incidents. Some of the interventions that may result from the Special Incident Reviews include but are not limited to movement of a resident from one unit to another due to peer conflict, peer conflict/mediation (if appropriate), additional clinical intervention placed on youth who are aggressive including separation from other peers for brief individual processing and counseling, All staff have been re educated on the role of protecting all youth through supervision and immediate responding and reporting when a peer on peer assault occurs, so that appropriate nursing follow up and incident reporting can occur. In addition, clinical therapists will provide additional direct care staff training each month during All Staff training, beginning 01/31/17. Such training will focus on the population served, and also address conflict resolution and de-escalations techniques.

Optional Comments:

Response Approved:

Yes

LOG INFORMATION SECTION

Report of Visit Delivery Date:

12/21/2016

Plan of Correction Due Date:

1/16/2017

Date Plan of Correction was Reviewed:

01/20/2017

Reviewed by:

L. Sanders, LPN

Comments:

Plan of Correction Approved:

Yes

Decision By:

L. Sanders, LPN

Decision Date:

01/23/2017

Remove POC:

UPLOAD DOCUMENTS

File Upload

Plan of Correction Log Number:

MPC01026-17

POC Accepted

Sanders, Lorie D.

Mon 1/23/2017 12:12 PM

To: lakeshia.coakley@uhsinc.com <lakeshia.coakley@uhsinc.com>;

1 attachments (123 KB)

POC letter Palmetto Pee Dee Residential.pdf;

Ms. Coakley,

Attached is the notification letter of the approved plan of correction for the investigation done at your facility on December 13, 2016.

Lorie D.Sanders, LPN
Complaint Department
South Carolina Department of Health and Environmental Control
Bureau of Health Facilities Licensing
Columbia Mills
Office: 803-545-4240
Fax: 803-545-4212

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January 23, 2017

PALMETTO PEE DEE RESIDENTIAL TREATMENT CENTER
601 GREGG AVE STE B
FLORENCE, SC 29501-4316

Confidential
Plan of Correction ID: MPC01026-17

PALMETTO PEE DEE RESIDENTIAL TREATMENT CENTER :

Thank you for submitting your Plan of Correction (POC) to an ivestigation report of visit dated December 13, 2016. As a result of our review, the Department accepts the facility's POC addressing the cited violations.

Sincerely,
Bureau of Health Facilities Licensing
(803) 545-4370